

**Continuing Healthcare and Funded Nursing Care   
 Appeal Procedure**

**May 2018**

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**1.0 Introduction**

1.1 This appeal procedure is created in accordance with paragraph 151 of the National Framework for NHS Continuing Healthcare (CHC) as revised in November 2012 (implemented on 1 April 2013). The National Framework for NHS CHC reflects the new NHS framework and structures created by the Health and Social Care Act 2012, effective from 1 April 2013. This document can be accessed via:

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf>

The guidance applies to time limits starting from 1 April 2012 for individuals or their families and representatives to request a review of an eligibility decision for NHS continuing healthcare funding by the local Clinical Commissioning Group (CCG) or responsible NHS body at a local level.

<https://www.gov.uk/government//news/eligibility-for-nhs-continuing-healthcare-funding-guidance>

The Regulations under the Act set out the Standing Rules to be followed when determining eligibility for NHS Continuing Healthcare and NHS Funded Nursing care (FNC), and this process is designed to set out a clear pathway as to how individuals, or their representative, may challenge eligibility for CHC.

This procedure refers to a challenge made by an individual or their representative following an assessment of eligibility for NHS CHC as an appeal, whereas the Standing Rules use the term ‘review’ for the same situation. Therefore when this document refers to an ‘appeal’ this equates to a ‘review of a decision’ regarding CHC eligibility made by a CCG.

1.2 This procedure is not for use where disputes arise between public bodies as to funding responsibilities or disagreement regarding a recommendation for funding made by the multi-disciplinary team (MDT). The procedure applies exclusively to patients registered with a Sheffield GP or any other patient for whom Sheffield CCG is the Responsible Commissioner, as defined by the Department of Health.

1.3 This procedure only applies to periods of care where eligibility for funding has been assessed. It does not apply to periods of unassessed care.

* 1. The Department of Health has set a time limit of 3 months for responsible CCGs to conduct an investigation and bring an appeal to its conclusion.
  2. If the Appeal cannot be resolved locally the individual or their representative can be referred directly to NHS England and subsequently the Parliamentary Health Service Ombudsman.

**2.0 The Role of the Appeals Nurse’s**

2.1 This Procedure sets out the procedure to be followed by the appeals nurse’s to determine whether an individual’s case is appropriate for consideration under the appeal procedures, in order to assess whether that individual has been wrongly denied NHS funding.

2.2 This procedure aims to:

* Adhere to the Standing Rules for Continuing Healthcare
* Provide transparency throughout the appeal process
* Adhere to guidance from the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in addition to the timescales set by the Department of Health (2012)
* Adhere to the NHS Continuing Healthcare Operational Procedure for Independent Review Panels (March 2013, revised)
* Adhere to the Guidance for Strategic Health Authorities and Primary Care Trusts on the time limits for individuals to request a review of an eligibility decision for NHS Continuing Healthcare Funding (15 March 2012)
* Adhere to the Core Values of the CCG when engaging with members of the public.

**3.0 Requests for an Appeal**

3.1 Where a CHC assessment has been carried out and the individual or their representative who holds the appropriate legal authority to do so wishes to challenge the outcome of the decision they must do so through the Local Resolution process.

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| **Local Resolution Process:**  The applicant is contacted by letter to acknowledge their letter of appeal and to request the rationale for their appeal, request proof of consent, identity and authority to act if appropriate  Once the appropriate consent has been received the Appeals Team will collate the relevant records and from health and social care in preparation for the Local Resolution Meeting. If required, meet the patient. Upon collation of all records an appeal report will be produced for consideration and discussion at the Local Resolution Meeting.  The Local Resolution Meeting provides an opportunity for the applicant to articulate why they disagree with the eligibility outcome. The Local Resolution Meeting will recommend whether based on information available and presented whether to close the case or return to the original MDT for further consideration.  The Local Resolution Meeting outcome is communicated in writing to the applicant including a copy of the minutes of the meeting. |
| **Local Resolution Process:**  Documents sourced from relevant health and social care organisations, the applicant’s views on why they disagree with the recommendation of the MDT, and the appeal nurse findings will be included in the appeals report by the appeals nurse.  **Possible outcomes:**   1. The MDT will be asked to reconsider the information and will make a decision based on this information if they wish to amend their original recommendation or not. Possible outcomes include:    1. If the recommendation is to be amended this will added to the appeal report by the Appeals Nurse on behalf of the MDT. For robustness, the appeals report will be attached to the DST under appeal. This will be checked by the Operational Lead Nurse, if the recommendation is agreed then a letter with the appeal report, outcome and explanation for the change in recommendation will be sent to the applicant advising that their Appeal has been upheld.    2. If the MDT do not feel that with the information presented by the appeals nurse would affect their recommendation this is acknowledged in the report by the appeals nurse. This information is checked by the Operational Lead Nurse and a letter with the appeal report and an explanation for no change in the recommendation and why there is no primary health need identified will be sent to the applicant. This letter will have the information on how to request an Independent review from NHS England. |

3.2 In cases where an individual does not have the mental capacity to manage their own affairs a representative may request an appeal of an eligibility decision on their behalf if they hold one of the following documents:

* A Lasting Power of Attorney which has been registered with the Office of the Public Guardian. This can be either a Health and Welfare Lasting Power of Attorney or a Property and Financial Affairs lasting Power of Attorney
* An Enduring Power of Attorney which has been registered with the Office of the Public Guardian
* An order of the Court of Protection appointing them as Deputy and the order enables them to decide to request a review of an eligibility decision
* An order from the Court of Protection, deciding that a review of eligibility should take place

Where no person holds any of the documents from the above list, each case will be considered on an individual basis taking into account what would be in the best interest of the individual.

3.3 All challenges must be received by the Sheffield CCG no later than 6 months from the date of the decision letter regarding eligibility.

3.4 A request for an appeal may be made in the following circumstances:

* Where an individual or their representative is dissatisfied with the   
   decision regarding eligibility for NHS CHC following completion of   
   the Decision Support Tool

or

* Where there has been a failure to follow National Guidance in  
   reaching its decision as to determine the individual’s eligibility for

NHS CHC.

3.5 A request for an appeal can only be made once the recommendation has been accepted by Sheffield CCG. The decision will remain unchanged until such time as the appeal is upheld. If, as a result of the Local Resolution process the decision is overturned, NHS funding will normally be back dated to the date when the assessment to which the appeal period relates to was completed.

* + Any refund will be in line with the Refunds Guidance incorporated in The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, 2012. This includes the revised information received by Her Majesty’s Revenue and Custom received March 2018.
* A copy of this procedure will be sent to all those who wish to challenge

a decision regarding eligibility.

3.6 The following challenges are outside the scope of this procedure:

* The content of the Department of Health National Framework for Continuing Healthcare and NHS-funded Nursing Care. These need to be pursued with the Department of Health
* The type and/or location of any offer of NHS funded Continuing Healthcare services or NHS treatment. See paragraph 10.0 below.
* The individual disagrees with the outcome of a screened out Checklist, the CCG may be asked to reconsider its decision through the standard NHS Complaints Procedure. The process followed is that the original referrer who completed the Checklist is asked to reconsider their evidence and weightings within the Checklist.

**4.0 Upon Receipt of a Request for Appeal:**

4.1 Challenges are preferably to be made in writing. If a challenge is made orally, the individual or family member must be encouraged or, where required, assisted to put their challenge in writing no later than 6 months from the date they were notified of the decision letter regarding eligibility for NHS CHC. Exceptionality criteria may apply to the above time limit (see section 9 below).

4.2 The applicant is contacted by letter within 5 working days of receipt of the challenge to acknowledge their letter of appeal and to request the rationale for their appeal, request proof of consent, identity and authority to act if appropriate. The acknowledgement letter will explain the appeal process and make every effort to ensure that the applicant has a clear understanding of the NHS CHC eligibility criteria and how it applies to their own situation.

4.3 Appropriate consent to discuss the appeal and share information should be sought by the Appeals Business Support Team, determined by the particularities of the individual case. In cases or a case where there is a lack of mental capacity the principles of the Mental Capacity Act 2005 will need to be applied.

4.4 Once the appropriate consent has been received the Appeals Team will collate the relevant records and from health and social care to complete the appeal report in preparation for the Local Resolution Meeting. If required, meet the patient. Upon collation of all records an appeal report will be produced for consideration and discussion at the Local Resolution Meeting.

4.5 The Local Resolution Meeting will recommend whether based on information available and presented whether to close the case or return to the original MDT for further consideration.

4.6 The Local Resolution Meeting outcome is communicated in writing to the applicant.

4.7 Where the individual to whom this decision relates to is deceased, the person requesting the appeal will need to provide evidence that they are an executor or administrator to the estate. If proof of this is not returned a decision will be made as to whether the appeal progresses under the auspices of the best interest process until the aforementioned legal documentation is made available. If such forms are not provided within 2 months, the application will be considered withdrawn, unless exceptional circumstances can be shown as to why the appeal should continue. Exceptional circumstances in this context means:

* an event or events which has significantly delayed supplying the grant of probate or letters of administration, which the person making the appeal was unable to control or influence; and
* The delay or delays was so lengthy as to make it impossible to meet the three month deadline.
* The CCG would expect regular communications from the applicant or their representative if grant of probate or letters of administration are being progressed.

**5.0 Local Resolution Meeting**

5.1 A Local Resolution Meeting (LRM) will be arranged after receiving notification of an appeal and collation of appropriate health and social care records, once consent is received, and the appeals report is completed.

5.2 LRM meetings will be digitally recorded and will ensure the following is adhered to:

* The patients or/and their relatives consent to the recording
* That the recording contains confirmation of time / date /participants
* The Dictaphone/ device used is encrypted.
* Audio files are removed from the device and stored on a protected networked system as soon as practically possible.
* Audio recording saved to the networked system should be stored in an unencrypted format, however, the protected network system denotes the access permissions and levels
* Audio recording would comply with the Records Retention Policy (see appendix)
* Any requests for copies of any digital recording would be subject to the CCG’s Subject Access Requests Policy.
* The device itself is periodically wiped to avoid accumulating recordings

5.3 During the LRM the appeals nurse will discuss with the applicant their rationale for appeal and use Appeals nurses report highlighting the domains which have been challenged; as a basis for discussion and formulation of agreed actions to be taken post LRM meeting. Only in exceptional circumstances would the CCG expect any further submission regarding the rationale for appeal.

5.4 Detailed notes will be taken at the meeting and shared with the applicant post LRM meeting.

5.5 The Appeal Nurse Assessor will assimilate the information provided at the meeting and will make a recommendation at the Local Resolution Meeting whether to either close the case or return to the original MDT for further consideration.

5.6 This recommendation will be communicated to the applicant at the meeting and their full participation is encouraged.

5.7 The final minutes and outcome of the LRM meeting will be communicated in writing to the applicant following authorisation by the Operational Lead for Continuing Healthcare or a nominated deputy.

**6.0 Gathering of Information**

6.1 Attempts should be made to access information from all reasonable sources to ensure a complete and robust review is undertaken. In the case of a deceased patient, the CCG will ensure that it makes every attempt to gather the relevant records for the period under review. However, in the unlikely event of no records being available this will have an impact on the CCG’s ability to complete a robust report to support the appeal.

6.2 The Appeal Nurse Assessor should address all the relevant points made by the applicant.

6.3 Whilst the Appeals team will request appropriate records in a timely manner, the Appeals team are reliant on external organisations providing this information in a timely manner. Failure to provide this information can have an impact on the CCG’s ability to conclude the appeal in a timely manner.

**7.0 Appeal Outcomes**

7.1 Documents sourced from relevant health and social care organisations, the applicant’s views on why they disagree with the recommendation of the MDT, and the appeal nurse findings will be included in the appeals report by the appeals nurse.

**Possible outcomes (post LRM meeting) are:**

**a.** Local closure of the appeal process as no additional information has been identified that would support a change in the recommendation of the DST under appeal.

b. Following discussion with the Appeals Nurse and MDT (using the information from the LRM) will reconsider the information and will make a decision if they wish to amend their original recommendation or not. Possible outcomes include:

* + 1. If the recommendation is to be amended this will added to the appeal report by the Appeals Nurse on behalf of the MDT. For robustness, the appeals report will be attached to the DST under appeal. This will be checked by the Operational Lead Nurse, if the recommendation is agreed then a letter with the appeal report, outcome and explanation for the change in recommendation will be sent to the applicant advising that their Appeal has been upheld.
    2. If the MDT do not feel that with the information presented by the appeals nurse this would affect their recommendation this is acknowledged in the report by the appeals nurse. This information is checked by the Operational Lead Nurse and a letter with the appeal report and an explanation for no change in the recommendation and this will be sent to the applicant.

c. All correspondence regarding appeal outcomes to include the information on how to request an Independent review from NHS England within 6 months of the outcome letter.

7.2 If the CCG fails to meet the 3 month timeframe, this will be communicated to the applicant via their preferred communication method or their representative explaining the reasons why this has not been achieved. Subsequent monthly updates will be provided including the reasons for the delay in the process.

**8.0 Challenges to the outcome of the Appeal**

8.1 In such cases where the individual fails to meet the eligibility criteria and the applicant remains dissatisfied with the outcome they have the right to request that the NHS England examine the evidence at an Independent Review. This request should be made no later than 6 months following the date the appeal decision letter was sent by the CCG.

**9.0 Exceptionality Criteria**

**(Regarding non-submission of an appeal by the Department of Health-stipulated 6-month time limit following notification of an eligibility decision)**

9.1 The CCG will consider whether there are exceptional circumstances and if a request for an appeal of recommendation should be considered outside of the deadlines. Each case will be considered on its individual merits.

9.2 In order to determine whether exceptional circumstances exist, the CCG will consider all relevant factors, including the following scenarios

9.2.1 If the individual lacked the capacity to understand the meaning of the deadline referred to in paragraph 3.3 (see above) and the steps they needed to take to request an appeal:

* Did they have anyone appointed to manage their affairs (e.g. an Attorney registered with the Office of the Public Guardian or a Court of Protection appointed Deputy)?
* If so, were there circumstances that meant such an Attorney or Deputy could not reasonably have been expected to know about the deadline (e.g. they were out of the country for the entire period or they were themselves incapacitated)?
* Was there any other individual who could reasonably have been expected to know about the deadline and its consequences for the individual?

9.2.2 If the individual had the capacity to understand the meaning of the deadline referred to in paragraph 3.2 and the steps they needed to take to request an assessment:

* Were there circumstances that meant the individual could not reasonably have been expected to know about the deadline (e.g. were they incapacitated)?

9.2.3 Was there an error on the part of any NHS body in processing a request for an appeal, which was received prior to the relevant deadline?

9.2.4 Examples of issues that are not exceptional include where a patient or their representative:

* believes they were unaware of the deadline for appealing despite a letter having been sent to the patient and representative stating that the deadline existed
* was unaware that care provided by the Local Authority is means-tested
* was unaware of a decision taken by the patient or a separate representative not to pursue an appeal and disagrees with that decision

The above list is illustrative and is not intended to be exhaustive.

**10.0 Appeals against an offer of care made by the CCG once eligibility is confirmed**

**10.1 Introduction**

Once continuing healthcare eligibility has been agreed, the continuing health care nurse

manager is responsible for formulating an offer of care to meet the individual’s needs.

This offer of care will be presented to the Continuing healthcare’s Resource Panel on the

appropriate documentation if appropriate.

For patients who are jointly funded the responsibility for formulating an offer of care to

meet the individual’s needs falls to a continuing healthcare nurse care manager and

social services care manager. This offer of care will be presented to the Continuing

healthcare’s Resource Panel on the appropriate documentation.

There should be evidence that a discussion and information has been given to the

individual and their family member/representative if appropriate around how the offer of

care meets the Commissioning Principles of the Clinical Commissioning Group (CCG)

The agreed package details will be communicated to the individual or their representative

in writing, the letter will provide information on how to Appeal the offer of care.

Timeframe to lodge an appeal is 1 week following the date of the offer of care letter.

**10.2 Role of the Care Manager**

This Procedure sets out the process to be followed by the care manager to determine whether an individual’s case is appropriate for consideration under the appeal procedures for the review of the offer of care, in order to assess whether that individuals care package meets the Commissioning principles of the CCG and that the evidence shows that identified care needs are being met.

This procedure aims to:

* Adhere to the commissioning principles of the CCG
* Adhere to the Standing Rules for Continuing Healthcare
* Provide transparency throughout the appeal process
* Adhere to the Core Values of the CCG when engaging with members of the public.

**10.3 Requests for an Appeal**

Appeals are preferably to be made in writing. If an appeal is made orally, the individual or

family member must be encouraged or, where required, assisted to put their request in

writing no later than 1 week from the date they were notified within the offer of care letter

explaining why they are appealing the offer.

Exceptionality criteria may apply to the above time limit (see section 9 above).

In cases where an individual does not have the mental capacity to manage their own

affairs a representative may request an appeal of an offer of care decision on their behalf

if they hold one of the following documents:

* A Lasting Power of Attorney which has been registered with the Office of the Public Guardian. This can be either a Health and Welfare Lasting Power of Attorney or a Property and Financial Affairs lasting Power of Attorney
* An Enduring Power of Attorney which has been registered with the Office of the Public Guardian
* An order of the Court of Protection appointing them as Deputy and the order enables them to decide to request a review of an eligibility decision
* An order from the Court of Protection, deciding that a review of eligibility should take place

Where no person holds any of the documents from the above list, each case will be considered on an individual basis taking into account what would be in the best interest of the individual.

**10.4 Upon Receipt of a Request for Appeal against an offer of care.**

The applicant is contacted within 5 working days by the appropriate continuing

healthcare team leader to acknowledge their letter of appeal and to request the rationale

for their appeal.

The Appeal Request will be reviewed by continuing healthcare team leader and

subsequently reviewed by the care manager, The care manager will be furnished with

all the appropriate documentation when the case was presented for consideration to

resource panel and the rationale provided by the applicant.

The care manager will consider all points expressed in relation to the appeal of the offer

of care and document on the Personalised Care Plan (PCP) any updated information

provided by the individual or family member/representative. A clinical view will be

incorporated and documented on the PCP paperwork.

The case will return to CCG’s Resource panel, the case will be reviewed and an

outcome letter will be forwarded to the individual or family member/representative within

4 weeks of the appeal being received. Any delays in this process will be

communicated to the applicant by the care manager or business support team.

**11.0 Mental Capacity Act (MCA 2005)**

11.1 Having considered and completed the MCA compliance statement at Appendix 1,

the MCA isapplicable to this policy.

**12.0 Equality Impact Assessment**

12.1 The document is underpinned by a clear process (see Appendix 2). No patient, for

any reason, either individually or by group, will be discriminated against by this process.

**13.0 Governance**

13.1 This guidance takes effect once authorised by the Chief Nurse.

13.2 The policy will be published on the CCG’s website until such a time it is reviewed and/or amended.

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| Current policy refreshed | By Alison Hall and Debbie Wade | 3/4/2018 |
| Circulated for comment to senior team members | By Debbie Wade | 3/4/2018 |
| Amendments made | By Alison Hall and Debbie Wade | 28/Sep/2018 |
| Final revised document submitted to QAC | By Debbie Morton | 26/Apr 2018 |

**Appendix 1 - Mental Capacity Act Compliance Statement**

Any policy, guideline or procedure which deals with circumstances where a service user has a decision to make, or has to be consulted, or their agreement is required, must include a **Mental Capacity Act policy compliance statement** setting out:

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| **Mental Capacity Act Compliance Statement** | Number of paragraph in policy, guideline or procedure where referenced or N/A |
| What service user decisions / consent / agreement may need to be sought during the operation of the policy / guideline or procedure | **3.2** |
| For each level of decision-making, who will be required to assess the client’s mental capacity at each level | **3.2 and 4.3** |
| What decisions staff may **not** make under the policy / guideline / procedure | **1.2** |
| How the existence of advance decisions, an Enduring Power of Attorney, Lasting Power of Attorney or deputy will be identified and recorded | **3.2** |
| Any other specific guidance that the policy / guideline / procedure requires staff to follow in relation to mental capacity | **3.2 and 1.1** |

To provide practical support for staff, a link to the Mental Capacity Act 2005 Implementation Guidance can be found at: <http://nww.sheffield.nhs.uk/policies/clinical.php#m> and can be included in the electronic version of the document being developed.

This **Mental Capacity Act compliance statement** is a consideration for all policies, guidelines and procedures. Where the MCA does not apply, authors need to make this clear in a statement to this effect inserted at the Mental Capacity Act section of the policy, guideline or procedure.